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Patricia E. Roberts

St. Mary's University School of Law, proberts6@stmarytx.edu

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PTSD, TBI, AND OTH DISCHARGES: A CASE STUDY OF A YOUNG SERVICE MEMBER

*Patricia E. Roberts**

I. INTRODUCTION

At the April 2016 conference, “Mission Critical Veterans Health Summit: Addressing the Invisible Wounds of Our Nation’s Veterans,” hosted by the Gitenstein Institute for Health Law and Policy (“Gitenstein Institute”) at the Maurice A. Deane School of Law at Hofstra University, one of the three panel discussions was entitled “Invisible Wounds: Case Study of PTSD from Several Perspectives.” As a panelist of that discussion, the author of this Article was tasked with addressing the legal and equity issues related to a young service member’s¹ Other Than Honorable (“OTH”) discharge.² Questions that the author identifies from

* Clinical Professor of Law at William & Mary Law School, Director of Clinical Programs, and Director of the Lewis B. Puller, Jr., Veterans Benefits Clinic. The author is grateful to Professor Janet Dolgin, Melissa Kessler and Michelle Wallace of the Gitenstein Institute for Health Law and Policy, fellow panelists Jennifer Gundlach, J.D., Keith Grant, Mayer Bellehsen, Ph.D., Ranak Trivedi, Ph.D., and Joseph De Santis and his staff on the *Hofstra Law Review*.

1. For discussion purposes in this Article, the author has taken the liberty of assigning John Doe to the U.S. Marine Corps (“USMC”), despite there being no designated branch of service in the case study as drafted by the Gitenstein Institute. The author chose the USMC because they have a higher percentage of OTH characterizations, as seen in the chart, “Enlisted Service Members Discharged as Percent of Characterized Discharges, FY11,” which shows the USMC with ten percent OTH discharges, while the next highest service branch, the Navy, has seven percent. VETERANS LEGAL CLINIC, LEGAL SERVS. CTR. OF HARVARD LAW SCH., UNDERSERVED: HOW THE VA WRONGFULLY EXCLUDES VETERANS WITH BAD PAPER 12 (2016).

2. When an active duty service member is separated after completing more than six months of military service, he or she receives a characterization of service assigned by their branch of service. See U.S. MARINE CORPS, ORDER 1900.16, MARINE CORPS SEPARATION AND RETIREMENT MANUAL (MARCORSEPMAN) ¶ 1011 (2013). The USMC defines characterization of service as “[c]lassification of the quality of service rendered.” *Id.* para. 1002. Discharge characterizations include Honorable, General (Under Honorable Conditions), OTH, Bad Conduct, and Dishonorable. See VETERANS LEGAL CLINIC, *supra* note 1, at 4-8. Prior options for characterization existed, including Undesirable and Without Honor. See *id.* at 5. Service members in the USMC that receive a discharge under OTH are deemed to have received the least favorable administrative discharge. See U.S. MARINE CORPS, *supra*, ¶ 1004(2)(c).

the case study—informed by her experience in representing veterans with post-traumatic stress disorder (“PTSD”) and traumatic brain injury (“TBI”) at the Lewis B. Puller, Jr. Veterans Benefits Clinic (“Puller Clinic”) at William and Mary Law School³—include whether Mr. Doe’s discharge status was fair; whether he should have had mandatory screenings for mental health issues during service or during his transition period out of service; and whether Mr. Doe can gain access to health care despite his OTH discharge and, if so, how. The case study prepared by the Gitenstein Institute and presented to the panelists and conference attendees, in its entirety, provides:

John Doe was deployed to Iraq from October 2006 until July 2007. On October 15, 2006, just two weeks after arriving in country, Mr. Doe stepped on an Improvised Explosive Device (IED) that left him with the following permanent injuries:

- Impaired hearing, with two perforated ear drums.
- Post-Traumatic Stress Disorder.
- A Concussion which led to the development of a traumatic brain injury (TBI).

Mr. Doe received a commendation and was returned to his unit while still dependent on prescribed medication to help with the post-IED injuries.

Just a few weeks later, Mr. Doe received another commendation for outstanding service after an explosion left two fellow service members severely injured. Mr. Doe carried one wounded soldier to the casualty collection point and returned, while under enemy fire, to treat the remaining soldier. Meanwhile, during this fierce nine-month deployment, Mr. Doe’s squad, which originally consisted of twelve men, was tragically reduced to just five; a rate of almost one a month.

Upon returning to base camp, Mr. Doe requested a mental health screening on his Post Deployment Health Assessment (PDHA). Mr. Doe stated that “everything seemed fine on the outside, but internally I couldn’t cope with everything I had gone through.”

Over the next several months, Mr. Doe was never directly instructed, at any time, by anyone in his chain of command nor was he advised by any medical officers to seek further medical attention. In fact, he was given no further treatment.

As a direct result, Mr. Doe self-medicated with narcotics as a way of coping with PTSD and possible TBI from very traumatic combat engagements. Mr. Doe was given an *Other than Honorable* discharge for failing a drug test shortly thereafter and “was made an

3. *About the Clinic*, WM. & MARY L. SCH., http://law.wm.edu/academics/programs/jd/electives/clinics/veterans/about_the_clinic/index.php (last visited Nov. 26, 2016) (describing the Puller Clinic).

example in front of his whole unit for ‘popping a piss test.’” One of Mr. Doe’s legal advisors noted that Mr. Doe feared “[s]howing that he was mentally unfit for duty would be seen as a sign of weakness amongst his peers.” Mr. Doe “felt ashamed that the one thing he was trying to avoid, the disapproval of his peers, had now become a reality.”

A law firm with an excellent record of overturning OTH discharges (with facts similar to Mr. Doe’s) is working to do that. In the meantime, you have begun to think about how best to respond to Mr. Doe’s difficulties, assuming, first that the OTH is overturned and assuming, second, that it is not.

Panelists face a wide set of questions regarding how best to provide services that will assist Mr. Doe.⁴

II. ANALYSIS

In considering the first question of whether Mr. Doe’s discharge status was fair, were he to come to the Puller Clinic, the faculty and students would interview Mr. Doe to determine whether the behavior that prompted his discharge could have been caused by his service-connected disabilities of PTSD and TBI. To make this determination, we would look to the in-service diagnoses of PTSD and TBI, as well as utilize the lessons taught by partners at Virginia Commonwealth University’s Center for Psychological Services and Development,⁵ whose graduate psychology clinic faculty train Puller Clinic faculty and students to look for signs that may indicate additional undiagnosed or aggravated mental health issues,⁶ and the Puller Clinic’s in-house psychologist, who also provides training and consults with faculty and

4. GITENSTEIN INST. FOR HEALTH LAW & POLICY, MAURICE A. DEANE SCH. OF LAW AT HOFSTRA UNIV., JOHN DOE CASE STUDY—MISSION CRITICAL VETERANS HEALTH SUMMIT (2016) (on file with the Gitenstein Institute for Health Law and Policy, Maurice A. Deane School of Law at Hofstra University); see *Mission Critical Veterans Health Summit: Addressing the Invisible Wounds of Our Nation’s Veterans*, MAURICE A. DEANE SCH. L. HOFSTRA U., <http://scholarlycommons.law.hofstra.edu/hlpc/2016vethhealth> (last visited Nov. 26, 2016) (describing the panel discussions as well as the case study).

5. *Center for Psychological Services and Development*, VA. COMMONWEALTH U., <http://cpsd.vcu.edu/about> (last updated July 25, 2016) (describing the Center for Psychological Services and Development at Virginia Commonwealth University).

6. See *About the Clinic*, *supra* note 3. Dr. Beth Heller from Virginia Commonwealth University’s Center for Psychological Services and Development, and the graduate psychology students under her supervision, regularly present on the symptoms and causes of TBI, PTSD, and military sexual trauma (“MST”), the latter being an issue in approximately fifteen percent of Puller Clinic cases, as well as other diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders* (“DSM-5”) that may be present in veteran clients. Dr. Judy Johnson works part-time in the Puller Clinic advising students on similar issues on a case-by-case basis, determining when such testing and evaluation might be warranted, and either supervising psychology students engaged in that evaluation or referring clients out for that testing.

students to determine when a thorough psychological evaluation is warranted.⁷ In Mr. Doe's case, despite his existing diagnoses, he would likely benefit from an extensive battery of psychological and neuropsychological tests, which could confirm the diagnoses of TBI and PTSD and explore whether and how such diagnoses might have impacted his behavior in service, including the ultimate substance abuse that led to his separation. While such evidence will not exonerate Mr. Doe for the illegal behavior that was the cause of his discharge, it could provide evidence that Mr. Doe was self-medicating with narcotics to alleviate the symptoms of both TBI and PTSD he was experiencing and for which he was going medically untreated. That evidence could then be used as support for the discharge upgrade he is seeking.

Had Mr. Doe's command been more responsive to his complaints regarding his mental health needs and desire for screening, or considered that his PTSD or TBI symptoms might have impacted his behavior or caused him to self-medicate, it is likely that he would have been considered for a medical discharge rather than an administrative separation with an OTH characterization.⁸ A marine being separated must have a medical evaluation not less than six months from separation; if, due to the Marine's health at the time of the evaluation, the medical professional deems it necessary, he or she can be referred to the Physical Evaluation Board ("PEB") for consideration of a potential medical disability that might warrant a medical, rather than administrative, separation from service.⁹

The U.S. Department of Defense requires that "person-to-person deployment mental health assessments be conducted for each Service member deployed in connection with a contingency operation," with certain delineated exceptions, and that these mental health assessments be conducted four times at least 90 days apart, according to the following schedule: (a) within 120 days before deployment, (b) between 90 and 180 days after return from deployment, (c) between 181 days and 18 months after return from deployment, and (d) between

7. See *About the Clinic*, *supra* note 3. Dr. Johnson began working with the Puller Clinic in 2014 as a result of funding received from the Virginia General Assembly to allow the Puller Clinic to continue the holistic legal and psychological services it provides to veterans, and the interdisciplinary teaching provided to graduate students.

8. See U.S. MARINE CORPS, *supra* note 2, ¶ 1011(3).

9. See D. C. ARTHUR, U.S. DEP'T OF THE NAVY, *MANUAL OF THE MEDICAL DEPARTMENT CHANGE 120* (2005), <http://www.med.navy.mil/directives/Documents/NAVMED%20P-117%20%28MANMED%29/MMDChapter18.pdf>. The *Manual of the Medical Department* ("MANMED"), which governs the USMC as well as the Navy, along with the Medical Evaluation Board Report ("MEBR") can, among other options, refer the case to the PEB for disability adjudication and determination of fitness for continued service. See *id.*

18 and 30 months after return from deployment.¹⁰ There do not appear to be requirements for mandatory mental health screenings during deployment.

Mr. Doe's experiences while deployed put the Marines on notice that he warranted evaluation, follow-up, and perhaps treatment while on that deployment. First, he received a diagnosis following an improvised explosive device ("IED") blast that included a PTSD and a TBI. PTSD is defined as "exposure to actual or threatened death, serious injury or sexual violation," which results from one of the following: direct experience of the traumatic event; witnessing a traumatic event personally; learning a traumatic event occurred to someone close; or repeated exposure, other than through media, of the details of the traumatic event.¹¹ PTSD is present when the foregoing traumatic event exposure causes "clinically significant distress or impairment in the individual's social interactions, capacity to work or other important areas of functioning," and is not due to drugs, alcohol, or other medical conditions.¹² TBI occurs when there is an injury to the head; a concussion is the mildest type of TBI and can cause such symptoms as headache or neck pain, nausea, ringing in the ears, dizziness, and tiredness.¹³ Symptoms present when there is a moderate or severe TBI might include worsening or constant headache, repeated vomiting or nausea, convulsions, seizures, difficulties waking up, slurred speech, weakness or numbness in the extremities, and dilated pupils.¹⁴ According to the Defense and Veterans Brain Injury Center, 49,000 Marines have been diagnosed with TBI since 2000, the majority of which involved concussions, and the National Center for PTSD estimates that between eleven and twenty percent of Iraq and Afghanistan veterans suffer from PTSD on an annual basis.¹⁵

10. U.S. DEP'T OF DEF., INSTRUCTION NO. 6490.12, MENTAL HEALTH ASSESSMENTS FOR SERVICE MEMBERS DEPLOYED IN CONNECTION WITH A CONTINGENCY OPERATION (2013).

11. AM. PSYCHIATRIC ASS'N, POSTTRAUMATIC STRESS DISORDER 1 (2013), <http://www.dsm5.org/Documents/PTSD%20Fact%20Sheet.pdf> [hereinafter AM. PSYCHIATRIC ASS'N, POSTTRAUMATIC STRESS DISORDER]. See generally AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (5th ed. 2013) [hereinafter AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL].

12. AM. PSYCHIATRIC ASS'N, POSTTRAUMATIC STRESS DISORDER, *supra* note 11, at 1.

13. *Traumatic Brain Injury*, MEDLINE PLUS, <https://medlineplus.gov/traumaticbraininjury.html> (last updated Nov. 4, 2016).

14. *Id.*

15. Lance M. Bacon, *New Policy Protects Marines, Sailors Facing Separation for Mental Health Issues*, MARINE CORPS TIMES (June 8, 2016), <https://www.marinecorpstimes.com/story/military/2016/06/08/new-policy-protects-marines-sailors-facing-separation-mental-health-issues/85609534>.

Soon after Mr. Doe suffered the IED blast and was diagnosed with PTSD and TBI, he engaged in heroic behavior saving fellow marines during a traumatic grenade explosion. Next, his unit suffered significant human losses over his nine-month deployment. These events could have exacerbated the initial injuries of PTSD and TBI, given that they involved additional exposure to the traumas that can trigger PTSD; and, the fact that TBI can cause changes in thinking, sensation, language, or emotions, which may have all exacerbated his emotional reaction to the traumatic and stressful events.¹⁶ Both the PTSD and TBI were service-connected injuries that should have initiated follow-up and further treatment throughout the deployment.¹⁷ During his post-deployment health assessment, Mr. Doe asked for a mental health screening, and there is nothing in the case study indicating that such a screening was provided either at his urging or in accordance with the required Department of Defense mental health screening schedule post-deployment. Instead, the facts provide that “[o]ver the next several months, Mr. Doe was never directly instructed, at any time, by anyone in his chain of command nor was he advised by any medical officers to seek further medical attention,” and “he was given no further treatment.”¹⁸

Mr. Doe began self-medicating to alleviate his symptoms, which is when he eventually took the urine test that showed he was using narcotics.¹⁹ Had Mr. Doe been provided with a mental health screening and follow-up treatment for his PTSD and TBI, he may have been able to prevent the self-medicating, which often occurs in those who suffer from PTSD and TBI²⁰ and ultimately led to his OTH discharge. Given the service-connected injuries he suffered, the follow-up traumas he endured, and his request for a mental health screening upon completing deployment, his command should have provided such screening.

Had Mr. Doe’s conduct and pending discharge occurred after June 1, 2016, when the Secretary of the Navy issued a new administrative separation policy, the outcome of his case might have been different. This is because, according to the new policy:

16. AM. PSYCHIATRIC ASS’N, POSTTRAUMATIC STRESS DISORDER, *supra* note 11, at 1.

17. Those suffering from PTSD often exhibit behavioral symptoms—such as re-experiencing the event, avoidance, negative thinking and mood, and arousal, all of which might benefit from mental health treatment—and behaviors that, if left untreated, are likely to cause a negative impact on the individual, personally and professionally. *See id.* Those suffering from severe TBI often require rehabilitation. *Traumatic Brain Injury*, *supra* note 13.

18. *See supra* note 4 and accompanying text.

19. *See supra* note 4 and accompanying text.

20. NAT’L COUNCIL ON DISABILITY, INVISIBLE WOUNDS: SERVING SERVICE MEMBERS AND VETERANS WITH PTSD AND TBI 21 (2009).

Sailors and Marines being processed for any type of involuntary administrative separation . . . who have a diagnosed mental health condition may be referred into the Disability Evaluation System . . . and if that Sailor or Marine is being administratively processed under provisions that authorize a characterization of service of other than honorable, the case must be referred to the first general officer/flag officer in the chain of command for a final determination.²¹

This new policy increases the likelihood that, due to his PTSD and TBI diagnoses, Mr. Doe would have warranted a referral into the Disability Evaluation System for possible medical separation and require that his OTH receive a higher level review to determine if the medical condition contributed to the alleged misconduct.²² Although the case study happened earlier than the effective date of the U.S. Secretary of the Navy's new administrative separation policy, the policy does note that veterans diagnosed with PTSD and TBI, and separated previously for an OTH, may petition to have their discharge reviewed through either the Discharge Review Board or Board for Correction of Naval Records to have those medical conditions taken into account.²³ Further guidance had been provided to the Military Department Boards for Correction of Military and Naval Records when considering discharge upgrade requests for previously unrecognized PTSD by U.S. Secretary of Defense Charles Timothy Hagel in 2014. Hagel's directive instructed that "liberal consideration" be given when service treatment records indicate one or more symptoms of PTSD or related conditions were present in service, or where civilian providers have opined such diagnoses were present at time of service, and that those diagnoses were potential mitigating factors in the misconduct.²⁴

Mr. Doe's OTH discharge will have some very significant and life-long consequences for him, as it would for any veteran. Veterans with OTH discharges, as well as those discharges characterized as Undesirable, Bad Conduct, and Dishonorable, are often referred to as having "bad paper" discharges ("BPDs").²⁵ Veterans with BPDs are

21. Press Release, Chief of Info. for Pub. Affairs, U.S. Dep't of the Navy, SECNAV Announces New Administrative Separation Policy (June 1, 2016), http://www.navy.mil/submit/display.asp?story_id=94996.

22. *Id.*

23. *Id.*

24. Memorandum from Charles Timothy Hagel, U.S. Sec'y of Def., to Sec'ys of the Military Dep'ts (Sept. 3, 2014) (on file with the Hofstra Law Review).

25. This issue is getting increased attention on Capitol Hill, where there is Senate language in the proposed annual defense authorization bill that would require the U.S. Department of Defense to review and improve the discharge process. See Leo Shane III, *Advocates, Lawmakers Push for Answers to Problem of 'Bad Paper' Discharges*, MIL. TIMES (Sept. 13, 2016), <http://www.>

more likely to be suffering from mental health conditions, such as the signature injuries of the current conflict, PTSD and TBI;²⁶ twice as likely to commit suicide (thirty percent higher rate for those outside of VA care);²⁷ more likely to be homeless (seven times as likely as other veterans);²⁸ and more likely to be involved in the criminal justice system²⁹ (and with a BPD, they are excluded from participation in nearly half of the nation's veteran treatment court initiatives).³⁰ They typically receive no VA assistance, including health care, as they are not entitled to such benefits with a BPD.³¹ Phil Carter, an Iraq War veteran and senior fellow, counsel, and director of the Military, Veterans and Society Program at the Center for a New American Security, noted in an interview with National Public Radio ("NPR") that "[t]here's a very, very large cost to society by giving bad paper" because denying veterans life-long benefits shifts the burden of care to non-profit organizations and local clinics, which do not have the infrastructure in place to enable them to absorb the care of our veterans on a long-term basis.³² The lack of health care, in particular, is extremely problematic in instances where, like in Mr. Doe's case, the service-connected disabilities require medical treatment in order to overcome the symptoms and, at times, undesirable behavior that the veteran needs treated in order to successfully reintegrate into civilian life.

There are limited exceptions to these benefit exclusions for OTH discharges.³³ For instance, those veterans who are victims of military

militarytimes.com/articles/bad-paper-discharges-rally.

26. *Veterans and Bad Paper: The Facts*, SWORDS TO PLOWSHARES (Jan. 2016), <https://commissiononcare.sites.usa.gov/files/2016/03/Veterans-and-Bad-Paper-The-Facts.pdf>.

27. *Id.*

28. *See* VETERANS LEGAL CLINIC, *supra* note 1, at 22.

29. *Id.* at 21.

30. JULIE MARIE BALDWIN, EXECUTIVE SUMMARY: NATIONAL SURVEY OF VETERANS TREATMENT COURTS 3 (2012), http://www.pacenterofexcellence.pitt.edu/documents/vet_court_paper.pdf ("[N]early half of [veterans treatment courts] exclude veterans who have been dishonorably discharged or have a current felony charge."); *The History*, JUST. FOR VETS, <http://justiceforvets.org/vtc-history> (last visited Nov. 26, 2016) ("As of June 30, 2014 there [we]re 220 Veterans Treatment Courts in our country with hundreds more in the planning stages."); *see also The Impact*, JUST. FOR VETS, <http://justiceforvets.org/vtc-impact> (last visited Nov. 26, 2016) ("In a 2004 report, the U.S. Department of Justice estimated there are over 700,000 veterans under criminal justice supervision.").

31. Marisa Peñaloza, *Path to Reclaiming Identity Steep for Vets with 'Bad Paper'*, NPR (Dec. 11, 2013, 4:58 AM), <http://www.npr.org/2013/12/11/249962933/path-to-reclaiming-identity-steep-for-vets-with-bad-paper>.

32. *Id.*

33. Some veterans with BPDs may be able to access VA-operated Vet Centers, including those who served in combat or who treated those injured in combat, who are having difficulties in readjusting to civilian life; services such as counseling and referrals are provided in those instances. *See* 38 U.S.C. § 1712A (2012).

sexual trauma are still entitled to health care despite their discharge status,³⁴ and those with BPDs can apply for an eligibility review with the VA despite their Character of Discharge (“COD”), not for a change in their discharge status but solely for the purpose of obtaining benefits.³⁵ However, only ten percent of veterans are even provided an eligibility evaluation.³⁶ Instead, most veterans are under the impression, or are erroneously told by VA employees, that they are simply ineligible for any benefits as a result of their BPD.³⁷ Veterans are typically not provided an eligibility evaluation when they seek homeless shelter services or assistance at a VA hospital or clinic. Such evaluations are initiated, if at all, when veterans apply for disability compensation from the Veterans Benefits Administration.³⁸

For those veterans who do go through the often lengthy COD process with the VA to determine whether their service could be characterized in a way that would make them eligible for benefits, the VA, using its own discretionary criteria rather than congressional statutory criteria, found in fiscal year thirteen that veteran service was “dishonorable” and ineligible for benefits in ninety percent of the cases it reviewed.³⁹ Even for veterans who appealed those initial decisions to the Board of Veterans’ Appeals, the results were abysmal; with a finding of dishonorable eighty-five percent of the time for all COD determinations from all eras.⁴⁰ For our case study, this means that Mr. Doe would leave service with his OTH discharge, ineligible for VA benefits to treat his PTSD, TBI, and other service-connected disabilities, other than limited counseling and referral services offered at VA Vet Centers to aid him in readjustment to civilian life, unless he fell within the ten percent of veterans who were provided an eligibility evaluation by the VA. Even if he were provided such an evaluation, only ten

34. VETERANS HEALTH ADMIN., DEP’T OF VETERANS AFFAIRS, VHA DIRECTIVE 2010-033, MILITARY SEXUAL TRAUMA (MST) PROGRAMMING (2010) (“Based on [38 U.S.C. § 1720D], the Department of Veterans Affairs (VA) provides counseling, care, and services to Veterans and certain other Servicemembers who may not have Veteran status, but who experienced sexual trauma while serving on active duty or active duty for training.”). The VA website also notes that these services are available to MST survivors. See *Military Sexual Trauma*, U.S. DEP’T VETERANS AFF., <http://www.va.gov/health/NewsFeatures/20120319a.asp> (last updated Apr. 17, 2015).

35. *VA Character of Service Determinations: An Alternative to Discharge Review*, SWORDS TO PLOWSHARES, <https://www.swords-to-plowshares.org/guides/character> (last visited Nov. 26, 2016).

36. See VETERANS LEGAL CLINIC, *supra* note 1, at 10.

37. *Id.*

38. *Id.*

39. *Id.* at 11.

40. *Id.*

percent of those veterans provided an evaluation received a positive COD review rendering them eligible for services.

In addition to Mr. Doe being ineligible for his post-service health care,⁴¹ except as available at VA Vet Centers, his OTH barred him from a physical evaluation board before separation⁴² and is likely to prevent him from receiving severance, disability compensation, or retirement pay due to his lack of status as a “veteran” for VA benefit purposes.⁴³ He is also ineligible for the Government Issue (“G.I.”) bill education benefits and the Yellow Ribbon program,⁴⁴ as well as local, state, and federal government preferential hiring.⁴⁵ Any civil service retirement credit for military service is lost,⁴⁶ and non-citizens with BPD cannot use their military service for naturalization credits.⁴⁷ Unemployment, health insurance protection, and burial rights in national or army cemeteries are also lost with an OTH discharge,⁴⁸ and many veteran service organizations restrict membership to only those with honorable discharges.⁴⁹ Mr. Doe’s OTH will also be evident on his DD-214 separation document⁵⁰ and will cause civilian employers to hesitate either when they see the document or when he fills out

41. 32 C.F.R. § 161.3 (2015).

42. See ARTHUR, *supra* note 9, at 18-23; Memorandum from Commandant of the Marine Corps to Distribution List (Aug. 7, 2015), <http://www.marines.mil/Portals/59/Publications/MCO%201900.16%20W%20CH1.pdf> (noting that article 18-5 of the MANMED provides for separation without the benefit of the disability evaluation system when separation proceedings may result in a characterization of service of OTH conditions, unless there is a significantly mitigating medical disability).

43. According to the VA, eligibility for most VA benefits is based upon discharge from active military service under OTH conditions. See *I Am a Veteran*, U.S. DEP’T VETERANS AFF., <http://www1.va.gov/opa/persona/index.asp> (last updated Aug. 8, 2016).

44. See *GI Bill Comparison Tool: About This Tool*, U.S. DEP’T OF VETERANS AFF., http://www.benefits.va.gov/gibill/comparison_tool/about_this_tool.asp (last updated July 15, 2016); *Yellow Ribbon Program*, U.S. DEP’T VETERANS AFF., http://www.benefits.va.gov/gibill/yellow_ribbon.asp (last updated June 29, 2016).

45. 5 U.S.C. §§ 2108, 3309–3316, 3502, 3504 (2012).

46. *Id.* §§ 8331–8332.

47. 8 U.S.C. §§ 1439–1440 (2012).

48. 5 U.S.C. §§ 8501, 8521; 38 U.S.C. §§ 2402, 4304 (2012); U.S. DEP’T OF THE ARMY, ARMY REG. 290-5, ARMY NATIONAL CEMETERIES (1976).

49. Eligibility for membership is limited to veterans who have been honorably discharged or are still serving. See, e.g., *Membership Application*, AM. LEGION, <https://www.members.legion.org/CGI-BIN/lansaweb?webapp=EDMS+webtrn=NETINTRO+ml=LANSAXHTML+part=TAL+lang=ENG#legion-org-header> (last visited Nov. 26, 2016); *Join Dav*, DAV, <https://www.dav.org/membership/join-dav> (last visited Nov. 26, 2016) (noting that eligibility is for those who were discharged or retired from military service under honorable conditions); *Join Amvets*, AMVETS, <http://www.amvets.org/join> (last visited Nov. 26, 2016) (“AMVETS is a veterans service organization open to anyone who is currently serving, or who has honorably served, in the U.S. Armed Forces including the National Guard and Reserves.”).

50. *Welcome Veterans and Their Families to the DD214 Website!!*, WELCOME TO DD-214!, <http://www.dd214.us> (last visited Nov. 26, 2016).

applications disclosing his discharge status. While Mr. Doe has the opportunity to seek a discharge upgrade for his OTH with the Naval Discharge Review Board⁵¹ and, if unsuccessful there, then at the Board for Correction of Naval Records, such appeals are largely unsuccessful and can take one or two years to conclude at each level.⁵²

The VA is currently excluding 125,000 veterans (6.5%) who served since 2001 from basic VA benefits, including at least 33,000 who were deployed to Iraq or Afghanistan, as a result of their discharge status deeming them ineligible.⁵³ Three out of four veterans with BPD have PTSD or TBI and are being denied eligibility for health care and disability benefits,⁵⁴ even at the Board of Veterans' Appeals level, meaning those veterans who are most in need of assistance are going without it as they attempt to readjust to civilian life and overcome the symptoms associated with their service-connected, and often invisible, injuries. Mr. Doe's OTH discharge, and resulting lack of services, will put him at an increased risk of homelessness, incarceration, substance abuse, and suicide. In this case study, and in practice, the military should institute a mandatory health screening during deployment and follow-up evaluation and treatment, or at least comply with existing regulations regarding post-deployment evaluations, for any service member who undergoes traumatic events and head injuries in service, as Mr. Doe did, particularly when that service member specifically asks for such an evaluation. Had such an evaluation or follow-up been performed for Mr. Doe, he could have been treated professionally for his PTSD and TBI. Such treatment may have prevented his coping through self-medication, which resulted in his OTH, and a discharge characterization that will have long-lasting negative implications for his post-service life.

III. CONCLUSION

Even if Mr. Doe were still separated with an OTH, a more liberal and accessible eligibility evaluation and COD review by the VA at the time of separation, for a veteran with an in-service diagnosis of PTSD and TBI, could potentially have allowed Mr. Doe access to health care and services that would address those service-connected injuries and resultant substance abuse. Providing liberal review of combat veterans' discharge characterizations, especially when they are suffering from in-

51. *Naval Discharge Review Board (NDRB)*, ASSISTANT SECRETARY NAVY, <http://www.secnav.navy.mil/mra/CORB/Pages/NDRB/default.aspx> (last visited Nov. 26, 2016).

52. *Board for Correction of Naval Records*, ASSISTANT SECRETARY NAVY, http://www.secnav.navy.mil/mra/bcnr/Pages/FAQ_and_Key_Information.aspx (last visited Nov. 26, 2016).

53. See VETERANS LEGAL CLINIC, *supra* note 1, at 8.

54. *Id.* at 14.

service PTSD and TBI, will go a long way towards aiding their successful reintegration into our communities, and their healthy recovery from combat-related injuries, thus reducing risk of homelessness, criminal justice involvement, substance abuse, and suicide among our post-9/11 veterans.